No. 89-1679

In The

Supreme Court of the United States

October Term, 1990

SUMMIT HEALTH, LTD., MIDWAY HOSPITAL MEDICAL CENTER, THE MEDICAL STAFF OF MIDWAY HOSPITAL MEDICAL CENTER, MITCHELL FELDMAN, AUGUST READER, M.D., ARTHUR N. LURVEY, M.D., JONATHAN I. MACY, M.D., JAMES J. SALZ, M.D., GILBERT PERLMAN, M.D., MARK KADZIELSKI AND WEISSBURG AND ARONSON, INC.,

Petitioners,

v.

SIMON J. PINHAS, M.D.,

Respondent.

On Writ of Certiorari
to the United States Court of Appeals
for the Ninth Circuit

BRIEF OF THE ARIZONA HOSPITAL ASSOCIATION, CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, HEALTHCARE ASSOCIATION OF HAWAII, IDAHO HOSPITAL ASSOCIATION, MONTANA HOSPITAL ASSOCIATION, NEVADA HOSPITAL ASSOCIATION, OREGON ASSOCIATION OF HOSPITALS AND WASHINGTON STATE HOSPITAL ASSOCIATION, AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Does a claim under Section 1 of the Sherman Act, which fails to allege any nexus between the allegedly anticompetitive activity and interstate commerce, nevertheless meet the jurisdictional requirements of the Sherman Act, as interpreted by this Court in *McLain v. Real Estate Board of New Orleans*, 444 U.S. 232, 100 S. Ct. 502, 62 L. Ed. 2d 441 (1980)?

INTEREST OF THE AMICI CURIAE

Amici Curiae are state hospital associations located in the Ninth Circuit.[1] The hospital associations joining in this brief collectively account for 894 hospitals in Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington.[2] Each *amicus* association and its member hospitals are committed to maintaining high quality medical and hospital care. An essential part of establishing and monitoring quality care is local hospital peer review — the review by physician medical staff members of the professional practices and patient care at a specific hospital.

SUMMARY OF ARGUMENT

The Ninth Circuit effectively established a conclusive presumption that all peer review activity affects interstate commerce within the meaning of Section 1 of the Sherman Act, when it held:

> [P]eer-review proceedings have an effect on interstate commerce, a fact that can hardly be disputed. [Peer review] proceedings affect the entire staff at [a hospital] and thus affect the hospital's interstate commerce.

Pinhas v. Summit Health, Ltd., 894 F.2d 1024, 1032 (9th Cir. 1989). This rule is contrary to this Court's holding in

[1] The consents to file this brief, as required by Rule 37, have been separately filed with the Clerk.

[2] The hospital members of each *amicus* association account for the majority of the licensed hospitals in their states. The Arizona Hospital Association represents 83 member hospitals of a total of 100 hospitals in Arizona. The California Association of Hospitals and Health Systems has a membership of 477 hospitals out of a total of 560 licensed facilities in that state. Thirty of the 32 hospitals in Hawaii belong to the Healthcare Association of Hawaii. The Idaho Hospital Association includes 51 of the 52 hospitals in that state as members. Fifty-eight of the 60 licensed hospitals in Montana are members of the Montana Hospital Association; the Nevada Hospital Association similarly includes as members 20 of 27 hospitals in that state. The Oregon Association of Hospitals encompasses 69 member hospitals, with only three nonmember hospitals. The Washington State Hospital Association counts 106 hospital members from a total of 116 hospitals in Washington.

McLain v. Real Estate Board of New Orleans, 444 U.S. 232 (1980), that a plaintiff must allege and prove a demonstrable nexus between the defendant's alleged anticompetitive activity and interstate commerce and that "as a matter of practical economics" the challenged activity has a substantial effect on interstate commerce.

The present case involves a hospital's decision, as part of its peer review activities, suspending a physician's medical staff privileges. The problems presented by the Ninth Circuit's opinion are twofold. First, it mischaracterizes hospital peer review activities by assuming without basis that these activities always affect a hospital's entire staff and therefore have a substantial effect on interstate commerce. This assumption is factually incorrect; while some hospital peer review activities may affect interstate commerce, others clearly do not. Second, under the Ninth Circuit rule, all peer review activities automatically meet the interstate commerce requirement for Sherman Act jurisdiction. The Ninth Circuit improperly eliminates the necessity of proving any nexus between the illegal conduct and interstate commerce or proving that the illegal conduct has a substantial impact on interstate commerce.

ARGUMENT

I. Hospital Peer Review Activities Address Patient Care Practices At Individual Hospitals And Are Fundamentally Noneconomic Activities.

"Hospital peer review" is a catch-all phrase encompassing a number of different types of professional review activities

that take place within individual hospitals.[3] While hospital peer review activities are all generally directed towards establishing and maintaining the quality of care provided in individual hospitals, only a distinct portion of these intrinsically local activities involve limiting or terminating a physician's medical staff privileges or membership. There is certainly no economic basis for assuming, as the Ninth Circuit did below, that alleged anticompetitive activity dealing with the termination of a physician's privileges infects all of a hospital's peer review activities or the hospital in general and interstate commerce.

A. The Range of Hospital Peer Review Activities.

Hospital peer review activities are an individual local hospital's mechanisms for reviewing professional practices and patient care at that facility. *See Bredice v. Doctors Hospital,* 50 F.R.D. 249 (D.D.C. 1970), *aff'd,* 479 F.2d 920 (D.C. Cir. 1973). Each of the states represented by the *amici* mandate or regulate hospital peer review as a matter of state law.[4] State peer review statutes define the scope of regulated peer review activities in various ways, and each statute affords in-

[3] The case before the Court involves hospital peer review activities. "Peer review" in yet a more general sense encompasses a range of professional medical review activities, whether related to quality of care or the appropriate utilization of medical and hospital services. Medical societies, certifying specialty boards, third-party payors, government health programs and independent reviewing organizations often engage in some form of organized review, by peers, of professional medical services. McCain, "Protection and Disclosure of Medical Peer Review Information," *Health Law Handbook,* p. 423 (1989).

[4] Ariz. Rev. Stat. Ann. §§ 36-445 *et seq.* (1986 & Supp. 1989); Cal. Bus. & Prof. Code §§ 805 *et seq.,* § 2282 (West 1990), Cal. Civ. Code §§ 43.7-43.8 (West 1982 & Supp. 1990), Cal. Evid. Code §§ 1156-1157 (West 1986 & Supp. 1990); Haw. Rev. Stat. § 624-25.5 (1985), § 663-1.7 (Supp. 1987); Idaho Code §§ 39-1392, 39-1393 (1985 & Supp. 1990); Mont. Code Ann. § 50-16-201 *et seq.,* § 37-2-201 (1989); Nev. Rev. Stat. § 449.476, § 49.265 (1990), Nev. Admin. Code § 449.358; Or. Rev. Stat. §§ 441-015 *et seq.,* § 41.675 (1989); Wash. Rev. Code Ann. § 70.41.200, §§ 4.24.240-4.24.260 (1988 & Supp. 1990).

dividual hospitals latitude in meeting their obligations to review the quality of hospital and medical services. A.R.S. §§ 36-445 *et seq.* (requiring a hospital governing body to require physicians' medical staff members to organize into committees "to review the professional practices within the hospital or center for the purposes of reducing morbidity and mortality and for the improvement of the care of patients provided in the institution"); Wash. Rev. Stat. § 70.41.200(1) (adopting a more detailed laundry list approach in identifying mandated hospital peer review activities to include a quality assurance committee reviewing hospital services, a medical staff privileges sanction procedure for reviewing physician credentials as part of staff privileging and ongoing review, a system for continuous collection of hospital information on negative patient outcomes, and medical education programs intended to improve patient care).

The range of hospital peer review activities can be generalized into three areas: (1) credentialing health care providers for medical staff membership and particular clinical privileges; (2) general monitoring of ongoing professional practices and patient care; and (3) identification of substandard practices and providers. *See* Gosfield, "Medical Peer Review Protection in the Health Care Industry," 52 Temp. L.Q. 552, 563-64 (1979); Morter, "The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?" 74 Va. L. Rev. 1115 (1988). The potential exclusion of a physician from medical staff membership accounts for only a limited portion of the first and third categories.

The first of these peer review activities, credentialing, arises from individual hospitals' responsibility to review the professional competence of physicians seeking medical staff membership and privileges. *Darling v. Charleston Community Memorial Hospital,* 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966); *Elam v. College Park Hospital,* 132 Cal. App. 3d 332, 183 Cal. Rptr. 156

(1982); *Purcell v. Zimbelman*, 18 Ariz. App. 75, 500 P.2d 335 (1972). Usually, the hospital governing board delegates to its medical staff the duty to establish membership and privilege criteria, and review the education, training, experience and qualifications of specific applicant physicians. "The Report of the Joint Task Force on Hospital-Medical Staff Relationships," American Hospital Association & the American Medical Association, pp. 29-32 (Feb. 1985) ("AHA/AMA Joint Task Force Report"); Ruane, "Antitrust Implications of Medical Peer Review: Balancing the Competing Interests," 15 Pepperdine L. Rev. 111, 114 & n.22 (1987).

Second, hospital peer review encompasses ongoing monitoring of a hospital's practices as measured against quality standards established by the individual institution. Peer review committees within each hospital develop institution-specific quality criteria for medical procedures. They then evaluate ongoing patient care against the criteria. AHA/AMA Joint Task Force Report, pp. 32-33. For example, the primary hospital accrediting organization, the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") requires a hospital's medical staff to monitor, as part of basic quality review programs, a broad spectrum of patient care concerns, including surgical cases, drug usage, the quality of medical records, pharmacy and therapeutic functions and risk management activities relating to patient care and safety. JCAHO Accreditation Manual for Hospitals, MS.6.1, pp. 111-15 (1990). These continuous monitoring activities allow hospitals to identify potential quality of care concerns based upon the specific quality standards set by the institution.

Third, hospital peer review activities also involve reviews of individual professional practices and identification of substandard physicians. In some cases, this area of peer review activities may result in disciplinary action against a physician, including potential limitation or termination of medical staff membership or clinical privileges. *Doe v. St. Joseph's Hospital of Fort Wayne*, 788 F.2d 411 (7th Cir. 1986)

(summary suspension of medical staff member's privileges because of unprofessional conduct); *Sarin v. Samaritan Health Center*, 813 F.2d 755 (6th Cir. 1987) (termination of medical staff privileges and membership because of professional competence concerns). The subject of the instant case involves one aspect of this element of peer review.

However, exclusionary action is by no means the primary focus of this area of hospital peer review. A peer review committee engaged in these activities may also identify specific patient care concerns and, in response, may impose educational and training requirements on an individual practitioner, specific supervisory requirements, concurrent review of a practitioner's work or retrospective review of a practitioner's patient records. *See* AHA/AMA Joint Task Force Report, pp. 33-34; *Hayden v. Bracy*, 744 F.2d 1338 (8th Cir. 1984) (peer review committee requirement that physician must attend additional medical education); *Setliff v. Memorial Hospital of Sheridan County*, 850 F.2d 1384 (10th Cir. 1988) (peer review results in requirement that physician secure second opinion before performing specific procedure); *Rhee v. El Camino Hospital District*, 201 Cal. App. 3d 477, 247 Cal. Rptr. 244 (1988) (peer review committee requires ongoing monitoring of physician's surgical cases during extended probationary period).

The Ninth Circuit in this case wrongly assumed, without engaging in any factual or economic analysis, that peer review activities always affect all medical staff members and the hospital itself and therefore always have a substantial effect on interstate commerce. As shown above, the scope of hospital peer review is wide-ranging; the effects of these various peer review activities cannot be generalized. A credentialing or disciplinary decision may affect an individual physician, but not affect any other medical staff member's ability or opportunity to provide care at the facility. General monitoring of the quality of medical practices may involve specific physicians in a given specialty without affecting

other medical staff members or the provision of hospital services.

B. Peer Review Is a Fundamentally Noneconomic Activity.

The purposes and processes of peer review discussed above lead to the conclusion that peer review is a fundamentally noneconomic activity. The United States Congress recognized this point in the legislative history of the Health Care Quality Improvement Act of 1986:

> Unlike other activities that may trigger antitrust lawsuits, properly limited peer review plays no essential or important economic role in the practice of medicine. Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review.

H.R. Rep. No. 99-903, 99th Cong., 2d Sess. 3 (1986), *reprinted in* 1986 U.S. Code Cong. & Admin. News 6384, 6385.

Congress' reasoning rests on the very basis of peer review. A hospital's peer review activities do not bring the consumer of health care services and the health care provider together. As a general matter, no fee is charged for peer review activities. Peer review activities do not necessarily affect either the frequency with which medical services are provided or the economic terms of providing those medical services. Nor do peer review activities affect the demand for medical services. The demand for these services is, in large part, inelastic. *See Hospital Corp. of America v. Federal Trade Commission*, 807 F.2d 1381 (7th Cir. 1986), *cert. denied*, 481 U.S. 1038 (1987).

Likewise, prices for medical services are not generally bargained for between patient and hospital or patient and doctor but rather are most frequently set by negotiation between third-party payors and providers irrespective of the particular physician-patient-hospital relationship involved. *See Kartell v. Blue Shield of Massachusetts*, 749 F.2d 922, 925-26 (1st Cir. 1984), *cert. denied*, 471 U.S. 1029 (1985);

Ball Memorial Hospital v. Mutual Hospital Insurance, Inc., 784 F.2d 1325, 1334 (7th Cir. 1986); *Hospital Corp. of America*, 807 F.2d at 1388. Hospital peer review activities do not affect the price at which a hospital will provide its services. The Ninth Circuit standard ignored these fundamental realities of peer review, without factual support.

C. Peer Review Activities May or May Not Substantially Affect Interstate Commerce.

As detailed above, hospital peer review activities are largely local, and they may or may not have an effect on interstate commerce. For example, a surgeon may be required as part of a peer review proceeding to attend additional continuing medical education as a condition for maintaining his privileges. Contrary to the Ninth Circuit's holding below, in a challenge by the surgeon under the Sherman Act, defendants legitimately may dispute whether such educational activities in any way affect the flow of interstate commerce. Are more patients operated on? Are the hospital or physician fees for services increased? These fact-intensive questions must be answered in each antitrust case.

Even when a physician has her privileges restricted or revoked as a result of peer review activities, and is ultimately excluded from the staff, an effect on interstate commerce does not inevitably follow. The excluded physician's patients may well be treated by different doctors at the same hospital and at the same price. In that case there is no demonstrable effect on interstate commerce. Even if an excluded doctor takes his patients across the street to another hospital, there is no reason to assume that action affects the volume or price of hospital services in that same town. *See Sarin v. Samaritan Health Center*, 813 F.2d at 758.

There is simply no basis to assume, as the Ninth Circuit did, that the exclusion of a physician from the staff of a hospital inevitably results in any effect on interstate commerce. Exclusion does *not* necessarily have an economic anticompetitive effect on the hospital or physician. *See, e.g., Thompson v. Wise General Hospital*, 707 F. Supp. 849, 855 (W.D.

Va. 1989), *aff'd*, 896 F.2d 547 (4th Cir. 1990), *petition for cert. filed*, April 27, 1990 (no showing that "gain or loss of one [doctor] would have a noticeable effect on the amount of competition"); *Hayden v. Bracy*, 744 F.2d at 1343 (peer review requirement on physician to attend three months of post-graduate training did not have substantial competitive impact, since others covered his practice until his return).

On the other hand, cases may exist in which the result of a particular peer review activity does affect interstate commerce. For example, in a highly specialized practice area, exclusion of a physician from the staff in a given hospital may mean that the services are performed at a different hospital in a different state. There may be types of medicine where the demand is elastic or where the price is sufficiently negotiable that the presence or absence of given physicians may affect the quantity of dollars or goods that flow across state lines.

In short, the "practical economic analysis" must be case-specific. Broad generalizations in this area ignore the varied nature and effects of hospital peer review activities.

II. A Per Se Rule That Hospital Peer Review Activity Affects Interstate Commerce Is Not Required By *McLain*.

A. *McLain* Does Not Mandate or Support the Ninth Circuit's Decision in *Pinhas*.

This Court's most recent ruling on the interstate commerce requirement of the Sherman Act is in *McLain v. Real Estate Board of New Orleans*. We believe, along with the majority of circuits considering this issue[5] and many commentators[6] that *McLain* requires a plaintiff to plead and prove a demonstrable nexus between the alleged illegal activity and interstate commerce. The minority view only requires that the plaintiff prove that "defendants' business activities, independent of the violations, affected interstate commerce." *Western Waste Service Systems v. Universal Waste Control*, 616 F.2d 1094, 1097 (9th Cir.), *cert. denied*, 449 U.S. 869 (1980).[7]

In *Pinhas*, the Ninth Circuit's application of the *Western Waste* test to peer review resulted in Sherman Act jurisdiction whenever any hospital-specific peer review activities are challenged. The expansive test adopted in *Western Waste* and adapted to peer review in *Pinhas* effectively reads the interstate commerce requirement out of the Sherman Act, ignores critical analysis found in *McLain*, and automatically transports fundamentally local hospital peer review activity into the federal realm.

This Court held in *McLain* that to establish jurisdiction in a Sherman Act case, the defendants' activities infected by the price-fixing conspiracy must be shown " 'as a matter of practical economics' to have a not insubstantial effect on the interstate commerce involved." 100 S. Ct. at 511. The plaintiff has the burden of proof. The *McLain* Court then tested the facts against this standard, and determined that they demonstrated the existence of a practical economic effect:

> It is clear, as the record shows, that the function of respondent real estate brokers is to bring the buyer and seller together on agreeable terms. For this service the

[5] *See, e.g., Stone v. William Beaumont Hospital*, 782 F.2d 609, 613-14 (6th Cir. 1986); *Seglin v. Esau*, 769 F.2d 1274, 1280 (7th Cir. 1985); *Hayden v. Bracy*, 744 F.2d 1338, 1342-43 (8th Cir. 1984); *Furlong v. Long Island College Hospital*, 710 F.2d 922, 925, 926 (2d Cir. 1983); *Crane v. Intermountain Health Care, Inc.*, 637 F.2d 715, 719, 722-24 (10th Cir. 1980).

[6] P. Areeda and H. Hovenkamp, *Antitrust Law*, § 232.1, at 238-39 (Supp. 1989); P. Kissam, W. Webber, L. Bigus & J. Holzgraefe, "Antitrust and Hospital Privileges: Testing the Conventional Wisdom," 70 Calif. L. Rev. 595, 634 (1982); Note, "Expanding Federal Antitrust Jurisdiction: A Close Look at *McLain v. Real Estate Board, Inc.*," 19 Hous. L. Rev. 143, 168-73 (1981).

[7] *See, e.g., Shahawy v. Harrison*, 778 F.2d 636, 639-40 (11th Cir. 1985), *amended*, 790 F.2d 75 (11th Cir. 1986); *Cardio-Medical Assocs. v. Crozer-Chester Med. Ctr.*, 721 F.2d 68, 74-75 (3d Cir. 1983).

> broker charges a fee generally calculated as a percentage of the sale price. Brokerage activities necessarily affect both the frequency and the terms of residential sales transactions. Ultimately, whatever stimulates or retards the volume of residential sales, or has an impact on the purchase price, affects the demand for financing and title insurance, those two commercial activities that on this record are shown to have occurred in interstate commerce.

100 S. Ct. at 511. As discussed in Section I, this sort of practical economic analysis frequently yields a much different result when applied as a factual matter to peer review activities. Peer review is not a commercial activity bringing the patient and physician together for a fee, nor do peer review activities necessarily affect the frequency, price or medical availability of the provision of medical services.

Those advocating a broad reading of *McLain* misconstrue the Court's statement that:

> Petitioners need not make the more particularized showing of an effect on interstate commerce caused by the alleged conspiracy to fix commission rates, or by those other aspects of respondents' activity that are alleged to be unlawful.

100 S. Ct. at 509. *McLain* involved a brokerage price-fixing case where there was simply no way to separate the price-fixing activity on the brokerage fee from brokerage services generally. Therefore, the plaintiffs met the interstate commerce requirement once they demonstrated that real estate brokerage activities in general affected interstate commerce. If the Court had intended to adopt the broader view, it would not have been necessary to engage in its practical economic analysis or concern itself with whether the price-fixing activity infected the defendants' business. The only question would have been whether there was any relationship between the defendants' business and interstate commerce.

B. *Pinhas* Ignores *McLain's* Standards.

Initially, the Ninth Circuit opinion below seemed to recognize that it is not appropriate to include any and all hospital activities in analyzing the interstate commerce jurisdictional question. The court held that:

> Pinhas must show that "as a matter of practical economics" the activities of the appellees — the peer review process in general — have a "not insubstantial effect on the interstate commerce involved."

894 F.2d at 1032. However, in the next sentence the Ninth Circuit assumed its conclusion rather than engaging in any economic analysis, holding that plaintiff "need only prove that peer-review proceedings have an effect on interstate commerce, *a fact that can hardly be disputed.* The proceedings affect the entire staff at [the hospital] and thus affect the hospital's interstate commerce." *Id.* (emphasis supplied). As shown in the first section of this brief, there *can* be very great dispute over the interstate impact of particular peer review activities. The court's broad overgeneralization finds no support in the record and demonstrates a profound misunderstanding of the scope and individuality of peer review activities.

Amici do not urge a blanket rule that hospital peer review activities do not affect interstate commerce; what we object to is the conclusive presumption adopted by the Ninth Circuit. The overwhelming majority of courts which have examined the relationship between peer review activities and the Sherman Act's interstate commerce requirement correctly concluded that an excluded or disciplined physician must allege, and if challenged, prove, that the particular exclusionary activities themselves have a substantial effect on interstate commerce. *See, e.g., Sarin v. Samaritan Health Center,* 813 F.2d 755 (6th Cir. 1987); *Doe v. St. Joseph's Hospital of Fort Wayne,* 788 F.2d 411 (7th Cir. 1986); *Stone v. William Beaumont Hospital,* 782 F.2d 609 (6th Cir. 1986); *Hayden v. Bracy,* 744 F.2d 1338 (8th Cir. 1984); *Furlong v. Long Island College Hospital,* 710 F.2d 922 (2d Cir. 1983);

Crane v. Intermountain Health Care, Inc., 637 F.2d 715 (10th Cir. 1980) (en banc). In some of these cases the plaintiff makes a sufficient showing of substantial effect upon interstate commerce; in others the opposite occurs. However, each of those cases focuses, as this Court mandated in *McLain*, on the practical economics of how the allegedly exclusionary peer review activities affected interstate commerce. The *Pinhas* court improperly bypasses that necessary analysis.

The Ninth Circuit assumes the conclusion that peer review always affects interstate commerce. As a result, the Ninth Circuit's decision mandates federal antitrust jurisdiction in *every* antitrust challenge to peer review, no matter how local the specific activity involved. This result is incorrect under *McLain*.

CONCLUSION

The judgment of the Ninth Circuit should be vacated and the judgment in the district court affirmed.

RESPECTFULLY SUBMITTED.

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